

SEP 4 1941

Registration District No. 58

Primary Registration District No. 5092

Registrar's No.

1. PLACE OF DEATH:

- (a) County Bates
- (b) City or town RFD Butler Mo. Pleasant (If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: /
- (If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution life (Specify whether years, months or days)
- In this community life

3. (c) PRINT FULL NAME

Gracie Lee Elsbury

3. (b) If veteran, name war
- X

3. (c) Social Security No.
- /

4. Sex
- F.

5. Color or race
- W

6. (a) Single, widowed, married, divorced
- infant

6. (b) Name of husband or wife
- infant

6. (c) Age of husband or wife if alive
- /
- years

7. Birth date of deceased
- March 14th 1940

(Month) (Day) (Year)

8. AGE:

Years 1Months 5Days 28

If less than one day

4 hr. / min.

9. Birthplace
- Bates Co. Missouri

(City, town, or county)

(State or foreign country)

10. Usual occupation
- /

11. Industry or business
- /

12. Name
- Sterling W. Elsbury

13. Birthplace
- Hazen Arkansas

(City, town, or county)

(State or foreign country)

14. Maiden name
- Goldie May Dordard

15. Birthplace
- Wisconsin

(City, town, or county)

(State or foreign country)

16. (a) Informant
- S. W. Elsbury

- (b) Address
- Butler Missouri

17. (a)
- Burial
- (b) Date thereof
- Aug. 24/41

(Burial, cremation, or removal)

(Month) (Day) (Year)

- (c) Place: burial or cremation
- Appleton City Mo.

18. (a) Signature of funeral director
- Booth Funeral Home

- (b) Address
- Butler Mo.

19. (a)
- Aug 24/41
- (b)
- Mrs. Pentina Bain

(Date received local registrar)

(Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

- (a) County Bates
- (b) City or town Butler RFD 6 (If outside city or town limits, write "RURAL")
- (d) Street No. / (If rural, give location)
- (e) Citizen of foreign country? / (Yes or No)
- If yes, name country /

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22 year 1941 hour 11 minute A M.

21. I hereby certify that I attended the deceased from NO 11 to NO 19 that I last saw him alive on NO 19 and that death occurred on the date and hour stated above.

Immediate cause of death Unknown

Duration

Due to /Due to /

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations /Of autopsy /

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) /
- (b) Date of occurrence /
- (c) Where did injury occur? (City or town) (County) (State) /
- (d) Did injury occur in or about home, on farm, in industrial place, in public place? /

While at work? (Specify type of place) (e) Means of injury /

23. Signature
- Adrianedridge
- (M. D. or other)
- /

Address Cornel

RECEIVED

District Health Officer No. 7,

District File Number 9-41-1566

Date Filed 9-3-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

John G. Henderson

Licensed Embalmer No. **3585**

P. O. Address **Butler Missouri**

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27770

Registration District No. 58

Primary Registration District No. 5092

Registrar's No. _____

1. PLACE OF DEATH

- (a) County Bates
(b) City or town St. O. Butler
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT
FULL NAME Gracie L. Elsberry

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex F

5. Color or
race W

6. (a) Single, widowed, married,
divorced S

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if
alive _____ years

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

- (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal)

(Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____

- (c) City or town _____
(If outside city or town limits, write "RURAL")

- (d) Street No. _____
(If rural, give location)

- (e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 12
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him/her alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

- Due to _____

- Due to _____

- Other conditions _____
(Include pregnancy within 3 months of death)

- Major findings:
Of operations _____

- Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____

- (b) Date of occurrence _____

- (c) Where did injury occur? _____
(City or town) (County) (State)

- (b) Did injury occur in or about home, on farm, in industrial place, in public place?

- While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature _____ (M. D. or other) _____

- Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

SUPPLEMENTARY

